REMARKS FOR HENRY A. WAXMAN

BEFORE THE

MEDICARE ADVOCACY PROJECT

LOS ANGELES, CALF.

September 7, 1990

Thank you for inviting me to participate in your Medicare recognition program. I am pleased to join with you in celebrating the 25th anniversary of the enactment of Medicare. This marks an important milestone in the history of this program which is so essential to our senior citizens and to the disabled.

But, as all of you know only too well, our work is not finished. Indeed, the work of the Medicare Advocacy Project here in Los Angeles is witness to the consequences of our failure to fulfill the promise of Medicare.

Today, the Medicare program is threatened by the relentless

pressure to reduce Federal spending. Budget policies have driven many of the changes in Medicare in recent years, and the prospect for even larger reductions in spending looms before us.

And, yet, Medicare does not provide a full measure of protection for the health needs of seniors. Out of pocket expenses as a result of cost-sharing obligations of the program, uncovered prescription drugs and preventive health services, and virtually no long-term care benefits impose substantial financial burdens on seniors. Many beneficiaries have obtained private supplemental insurance to fill in Medicare gaps, but premiums for this coverage are growing rapidly. Through improvements to the Medi-Cal program, we have made it possible for some of our low income seniors to be eligible to have Medicare cost-sharing obligations paid by Medi-Cal. Nevertheless, many beneficiaries with low incomes are not eligible for Medi-Cal and cannot afford private insurance. For them, Medicare is far from adequate protection.

In this time of intense fiscal pressures, I believe it is imperative to

take special care to protect the important gains that Medicare represents, and to avoid increasing the financial burden of health care on the elderly. Moreover, I am particularly concerned about cuts in funding for Medicare that lead to a general deterioration in the quality of services and in the accessibility of services. We cannot continue, year after year, to reduce Medicare payments by billions of dollars without dangerous consequences. At some point, essential health facilities are driven out of business, and health professionals begin to withdraw from participation in the program.

I recognize that some of the funding cuts already made have violated these goals, and that there is the potential for deeper cuts in Medicare in the budget legislation before Congress later this year. I believe that reductions of the magnitude recommended by the President in his budget for next year -- over $5 billion in Medicare -- are excessive. Such cuts will further erode confidence in the program and threaten the financial well-being of many senior citizens.

I am particularly disturbed by growing interest in proposals to

increase the Part B premium and to double the Part B deductible. I intend to oppose these proposals, and to work for reasonable payment reductions that are consistent with the important payment reforms adopted in recent years. I need your support for these goals in the months ahead.

Let me spend the remainder of my time with you talking about some of the important reforms in Medicare that I supported last year, and the challenges we are facing in the new budget year which begins in October.

Medicare Physician Payment Reform

As you all have heard, Congress made some very sweeping changes in the way physicians will be paid for their services under Medicare, and in the enhanced financial protections afforded to beneficiaries with regard to balance billing by physicians.

First, beginning in 1992, Medicare will pay physicians on the basis

of a fee schedule reflecting the actual resources necessary to provide their services, and the overhead expenses of medical practice. Under these reforms, some physicians will receive lower payments from Medicare, while others will see their Medicare payments rise. In general, primary care services -- office visits and patient management services -- will increase in value. Conversely, some diagnostic and surgical procedures will decline in value. I supported these changes because I believe the result will be more equitable payment to physicians, and improved access of patients to primary care.

A second, critical component of these payment reforms was agreement on a new federal effort to evaluate medical practice and to develop practice guidelines for use by health professionals. There is accumulating evidence that some health care is unnecessary, ineffective, or even harmful. I believe an effort to more carefully evaluate health care services, and to develop more uniformity in the diagnosis and treatment of patients can improve quality and make better use of our scarce resources.

Third, it was obvious to me and others in Congress that as we re-designed the payment system for Medicare covered services, we needed to pay particular attention to the effect of these changes on the cost-sharing obligations of beneficiaries. As payments for some services fall, it is reasonable to expect that some practitioners would seek to recover Medicare payment cuts from patients by billing them for the difference between their charges and the Medicare fee schedule amount. This practice -- known commonly as balance billing -- has been limited by actual charge limits on doctors enacted several years ago, but these limits have not prevented substantial increases in the amount of extra bills.

Thus, last year's payment reform included tighter limits on balance billing of patients that go into effect in January. For 1991, physicians may not bill more than 25 percent more than Medicare's approved charge, and by 1993 that limit will be lowered to 15 percent. Even with such limits, I recognize that the out-of-pocket expenses for those who need care can still be large, particularly for those with neither Medi-Cal eligibility nor private supplemental insurance.

Finally, as part of our reform package last year, I supported a requirement for all practitioners and suppliers of Part B services to submit Medicare claims on behalf of patients along with a prohibition against billing the patient for this service. This provision became effective on September 1st. I know that you are very much aware of the complexity of Medicare billing procedures and the confusing notices of benefit payments provided by Medicare and private payers.

I think it is important to recognize that the Administration opposed this provision. They were aware that many Medicare claims are simply not filed by patients who are overwhelmed by the complexity of the process and do not have access to organizations like MAP that provide valuable assistance in the preparation of claims. Thus, Medicare saves money when beneficiaries fail to submit claims. It is appalling that we face opposition to policies which help Medicare patients get the services they need and are their right. I am hopeful that this requirement will ensure all beneficiaries receive their entitled benefits.

Status of Budget Negotiations

For the last several months leaders in Congress and representatives of the President have been trying to negotiate an agreement on how to continue reducing the federal deficit. This task has been exceedingly difficult in view of the extraordinary increase in the projected deficit for the next fiscal year, the demands of the savings and loan industry collapse, and, most recently, by our military build-up in the Middle East. The latest estimates forecast a deficit of at least $165 billion, not including the cost of the savings and loan bail-out. The original target for the deficit of $64 billion next year simply cannot be reached without doing unacceptable harm.

Although some revision in the deficit reduction target is likely, we are still facing the prospect of cuts in spending or increases in revenues of between $30 and $50 billion in FY91. My fear is that Medicare and Medicaid will be targeted for unprecedented cuts. As I mentioned earlier, there have been serious discussions within the Administration and by some in Congress to propose increasing the

Medicare Part B premium to a level that would finance 30 percent of the costs of Part B, and to increase the Part B deductible from $75 per year to $150. Such an increase in the Part B premium would result in an annual premium in 1991 of $434 compared to $359 under current law.

I think we can expect continued Administration pressure for deep cuts in Medicare and Medicaid. For my part, I have urged our leadership in the House to resist agreeing to Medicare cuts that undermine the payment reform we have launched, and which threaten the quality and accessibility of care. Moreover, I have also advocated setting aside some new revenues in future years to support critical initiatives in Medicaid and expansion of access to basic health benefits for all our citizens as recommended in the report of the Pepper Commission which I strongly supported. I do not believe we can afford to wait another five or ten years to address these fundamental gaps in access to health care.

Whatever the final outcome, I will need your support to ensure

that deficit reduction proposals do not impose unreasonable or excessive burdens on these vital health financing programs.

Conclusion

Let me conclude my remarks with a few words about the challenges and priorities we face in the decade ahead. We have over 31 million citizens who have no public or private health benefit protection. In addition, the Census Bureau recently reported that 63 million Americans went without health insurance coverage sometime during a recent 28 month period. That's almost 30 percent of our population!

This spring the Pepper Commission recommended a program to extend basic health care to the uninsured, using a combination of employer-based insurance and a new public program for those without employer coverage and the unemployed. The Commission also proposed a long-term care policy relying on a mix of both private and

public programs.

As a member of the Pepper Commission, I supported its recommendations. They are not perfect. I had hoped that the cost containment provisions would be stronger, and that financing for the new public program would relieve States of much of their current financial responsibility for providing basic coverage for the poor.

But the Commission's work will frame the congressional debate, and provide a blueprint for health system reform that is so long overdue. There is increasing impatience with the status quo, and a recognition that we must build a more effective public-private partnership to end this shameful failure to ensure access to basic health services to all our citizens.

The problem now is not a lack of vision, but an absence of leadership. Those with the responsibility to lead -- President Bush and his Administration -- have been either evasive or silent on these issues. While those of us in Congress who have endorsed the Pepper

Commission Report will press hard, we cannot make up for the lapse in leadership at the White House. One must conclude that health care is not among the priorities of this Administration.

In closing I want to again salute you and the work of MAP. I intend to support legislation which makes counseling services like those provided by MAP available to beneficiaries whatever they may live. I also look forward to further improvements in the Medicare program that make it more "beneficiary-friendly". With your advice and support, I am confident that we can make progress in the areas I have outlined despite the difficult financial challenges we face.

I want to thank you again for inviting me here today. I look forward to working with you as we move forward on America's health agenda.

(Note to HAW: If someone asks about the prospects for H.R.4772 by Kolter to repeal the requirement for physicians to submit all Medicare

claims, you can reply that while it has been introduced, you are not aware of any significant support for the measure, and would not expect to see it enacted.)